



Texas Department of Insurance

Division of Workers' Compensation

7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name and Address:

TROM INCORPORATED
3028 BRUSH CREEK LANE
FLOWER MOUND TX 75028

DWC Claim #:

Injured Employee:

Date of Injury:

Employer Name:

Insurance Carrier #:

Respondent Name:

CITY OF DENTON

Carrier's Austin Representative Box

Box Number 17

MFDR Tracking Number:

M4-05-A312-01

MDR Date Received:

JULY 12, 2005

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary as stated in the Table of Disputed Services: "Services preauthorized @ negotiated rate."

Amount in Dispute: \$807.00

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "The previous recommended allowance of \$55.31 for a thirty day rental includes date of service June 14 thru July 13, 2004. No additional allowance is recommended."

Response Submitted by: CCS Consulting, PO Box 541387, Dallas, TX 75354

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
June 14, 2004 through July 13, 2004	HCPCS Codes E0236 and L3999	\$807.00	\$484.69

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for health care providers to pursue a medical fee dispute.
2. 28 Texas Administrative Code §134.202 sets out the fee guidelines for reimbursement.
3. 28 Texas Administrative Code §134.1 provides for fair and reasonable reimbursement of health care in the absence of an applicable fee guideline and 28 Texas Administrative Code §133.307(g)(3)(D) which is related to health care for which the Division has not established a maximum allowable reimbursement.
4. Texas Labor Code §413.011 sets forth provisions regarding reimbursement policies and guidelines.
5. The services in dispute were reduced/denied by the respondent with the following reason codes:

Explanations of benefits were not submitted by either party.

Issues

1. Did the requestor submit the request for medical fee dispute resolution timely and in accordance with 28 Texas Administrative Code §133.307?
2. Did either party to the disputed service submit documentation to support a negotiated rate?
3. Did the requestor submit documentation to support fair and reasonable reimbursement for healthcare provided in the absence of an applicable fee guideline?
4. Is the requestor entitled to reimbursement?

Findings

1. Pursuant to 28 Texas Administrative Code §133.307(d)(1) the requestor timely submitted the request for medical fee dispute resolution.
2. The requestor states, on the table of disputed services, that the parties had a negotiated rate for the preauthorized services. Review of the documentation submitted by both the requestor and respondent finds no evidence of a negotiated rate agreed upon by the parties. Therefore, the services will be reviewed in accordance with 28 Texas Administrative Code §134.202(b) and (c)(2). The requestor billed HCPCS Code E0236-RR from June 14, 2004 through July 13, 2004 for a total of 30 units. According to the Durable Medical Equipment Fee Schedule the allowable amount is \$55.31 per unit. The requestor billed \$18.00 per unit for 30 days, totaling \$540.00; therefore, reimbursement in the amount of \$540.00 less the carrier payment of \$55.31 for a reimbursement of \$484.69.
3. The requestor billed \$267.00 for HCPCS Code L3999-NU, Upper limb water circulating orthosis, NOS. According to the preauthorization request the specific service requested was L2999, defined as lower extremity orthoses, NOS. Review of the HCPCS definition of L2999 shows that this code should be used only if a more specific code is unavailable. Since the compensable injury was a rotator cuff tear and AC orthoses of the right shoulder the requestor billed the correct HCPCS code. Center for Medicare and Medicaid Services does not price this code; therefore, in accordance with 28 Texas Administrative Code §133.307(g)(3)(D) the requestor did not submit documentation that discusses, demonstrates, and justifies that the payment amount being sought is a fair and reasonable rate of reimbursement. Reimbursement is not recommended.

Conclusion

For the reasons stated above, the division finds that the requestor has established that additional reimbursement is due. As a result, the amount ordered is \$484.69.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code §413.031, the Division has determined that the requestor is entitled to \$484.69 reimbursement for the disputed services.

Authorized Signature

October 5, 2012

Signature

Medical Fee Dispute Resolution Officer

Date

YOUR RIGHT TO REQUEST AN APPEAL

Either party to this medical fee dispute has a right to request an appeal. A request for hearing must be in writing and it must be received by the DWC Chief Clerk of Proceedings within **twenty** days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. The party seeking review of the MDR decision shall deliver a copy of the request for a hearing to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision* together with any other required information specified in 28 Texas Administrative Code §148.3(c), including a **certificate of service demonstrating that the request has been sent to the other party.****

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.